



## MULTIPLE SCLEROSIS AGENTS PA SUMMARY

Preferred	Non-Preferred
Avonex (interferon beta-1a) Copaxone (glatiramer acetate) 20 mg/ml Extavia (interferon beta-1b) Rebif/Rebif Rebidose (interferon beta-1a)	Ampyra (dalfampridine) Aubagio (teriflunamide) Betaseron (interferon beta-1b) Copaxone (glatiramer acetate) 40 mg/ml Gilenya (fingolimod) Plegridy (peginterferon beta-1a) Tecfidera (dimethyl fumarate)

**LENGTH OF AUTHORIZATION:** Varies based on medication requested

### PA CRITERIA:

#### *Ampyra*

- ❖ Approvable for the diagnosis of multiple sclerosis (MS) when prescribed by or in consultation with a neurologist or a MS-specialist.
- ❖ Member's estimated creatinine clearance must be measured before treatment initiation and at least annually and must be greater than 50ml/min.

#### *Aubagio*

- ❖ Approvable for relapsing forms of MS when prescribed by or in consultation with a neurologist or a MS-specialist.
- ❖ Member must have experienced trial and failure to achieve an adequate response or an inability to use 2 preferred products: glatiramer (Copaxone) and one interferon beta-1 (Avonex, Extavia, or Rebif).
- ❖ Transaminase and bilirubin levels should be obtained and evaluated within 6 months before treatment initiation and at least monthly for 6 months after starting therapy.
- ❖ Female members of reproductive potential must have pregnancy excluded before starting therapy and male and female members must use reliable contraception.

#### *Betaseron*

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, Extavia, is not appropriate for the member.

#### *Copaxone 40 mg/ml*

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, Copaxone 20 mg/ml (which is administered once daily), is not appropriate for the member.

#### *Gilenya and Tecfidera*

- ❖ Approvable for relapsing forms of MS when prescribed by or in consultation with a neurologist or a MS-specialist.



- ❖ Member must have experienced trial and failure to achieve an adequate response or an inability to use 2 preferred products: glatiramer (Copaxone) and one interferon beta-1 (Avonex, Extavia, or Rebif).
- ❖ For Gilenya, the first dose must be administered in a medical setting with a 6-hour observation period for signs of symptoms of bradycardia and an ECG must be completed at baseline and at the end of the initial dosing 6-hour observation period.

*Plegridy*

- ❖ Approvable for relapsing forms of MS when prescribed by or in consultation with a neurologist or a MS-specialist.
- ❖ Member must have experienced trial and failure to achieve an adequate response or an inability to use 2 preferred products: glatiramer (Copaxone) and one interferon beta-1a (Avonex or Rebif).

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827**.

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- ❖ For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.